EXHIBIT 3
DATE 1/17/2011
HB 129

Interim Final Regulations Relating to Internal Claims and Appeals and External Review Processes

The fifth set of regulations was jointly released by the U.S. Departments of Treasury, Health and Human Services, and Labor, with a formal publication date anticipated during the week of July 26, 2010. A 60-day comment period will follow from date of release. This rule, along with the other previously released rules, will be effective almost immediately.

The requirements to implement internal and external claims and appeals processes apply for plan years beginning on or after September 23, 2010. These requirements do not apply to grandfathered plans.

According to the rule's preamble, Congress enacted this section of law "[t]o ensure that plans and issuers implemented more uniform internal and external claims and appeals processes and to set a minimum standard of consumer protections that are available to participants, beneficiaries, and enrollees".

Internal Reviews

Sponsors of ERISA-covered group health plans were required to implement an internal claims and appeals process that complied with DOL claims procedure regulation. The PPACA rules will apply the ERISA claims and appeals rules including the ERISA time limits in total to all group health plans, insured and self-funded, whether they are ERISA plans or not. This will be a new requirement in the individual health market.

Six new requirements – claims regulations

Group health plans and health insurance issuers offering group health insurance coverage must comply with the existing ERISA claims regulations and six additional new requirements. These include:

* The definition of 'adverse benefit determination' subject to internal review includes any decision involving eligibility to participate in a plan or coverage; rescission of coverage; whether a service is a covered benefit; imposition of pre-existing condition and other benefit limits; and medical necessity and experimental treatment determinations.
* The current 72 hour timeframe for notifying a claimant of a benefit determination involving urgent care is shortened to 'as soon as possible' but no later than 24 hours.
* Additional criteria to ensure that a claimant gets a "full and fair review" such as providing claimants with the opportunity to review the claim file and present evidence and testimony.
* Additional conflict of interest criteria for claims adjudication and others.

* New standards for notice to enrollees related to content and for providing notice in a "culturally and linguistically appropriate manner".

* Where a plan or issuer fails to "strictly adhere" to all requirements of the internal claims and appeals process with respect to a claim, the claimant will be deemed to have exhausted the process and may then seek external review and pursue other legal remedies including judicial review.

External Reviews

New requirements for external appeals of adverse benefit determinations by group health plans and health issuers will come into play, though the rule provides a transition period for group health plans and issuers that are complying with existing state external appeals processes for plan and policy years beginning before July 1, 2011. After that date, state external review processes must be in compliance with minimum federal standards, as determined by the U.S. Department of Health and Human Services.

The big change is that self –funded group health plans must meet the external review compliance standards for plan years on or after September 23, 2010. A federal process will apply for these plan years. The preamble specifies that the Departments will release additional guidance or regulations concerning these standards at a later date. As currently written, these new rules seem to directly conflict with some very basic ERISA fiduciary duty requirements for appeals as stated in the regulations to section 502 and 503 of ERISA, so it appears that some additional amendment to those regulations may be required in order to implement the PPACA rules.

An analysis of existing external review processes will need to be undertaken by state and federal regulators in order to determine whether the state's external review statute contains the consumer protections in the National Association of Insurance Commissioners (NAIC) Uniform Health Carrier External Review Model Act. We anticipate state legislation in this area as the Montana statute on external appeals does not contain many of the protections set forth in the NAIC Model Act.

Overall Impact

Most plans already comply with the DOL/ERISA claims regulations, though there will be additional requirements on plans to make claims files available and to annually provide notices of appeals processes.

Self-funded group health plans will need to comply with federal external review processes to be further defined.